

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Buena Vida Nursing and Rehab Odessa		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 Englewood LN Odessa, TX 79762	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #1) reviewed for medication errors. The facility failed to administer Resident #1's glimepiride (an oral medication used to manage blood sugar levels in adults with type 2 diabetes). The medication was not available according to the signed MAR. This deficient practice could place residents at risk of inadequate therapeutic outcomes, increased adverse side effects, and a decline in health. Findings include: Record review of Resident #1's face sheet dated 09/30/25 revealed an [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of type 2 diabetes (chronic medical condition in which the body does not produce enough insulin or does not use insulin effectively), morbid obesity, and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of Resident #1's most recent quarterly MDS assessment, dated 6/11/25 revealed the resident had a BIMS score of 10 indicating moderate cognitive impairment for daily decision-making skills. Record review of Resident #1's care plan dated 08/08/25 indicated Resident #1 used diabetic medications. Interventions included to provide and document teaching to resident/family/caregiver and address identified roadblocks to compliance. Record review of Resident #1's physician orders included the following medications: Glimepiride oral tablet 1 mg-Give 1 tablet by mouth one time a day for diabetes mellitus-ordered 12/11/2024 Basaglar Kwik Pen subcutaneous solution Pen-injection 100 unit/ml-Inject 20 unit subcutaneously one time a day relate to type 2 diabetes mellitus-ordered 02/14/25 Becton [NAME] duo miscellaneous 30 g X mm. Inject 1 application subcutaneously before meals and at bedtime for diabetes mellitus-ordered 04/14/25. Record review of Resident #1's Medication Administration Record for July 2025 revealed the scheduled medication of glimepiride 1 mg was not administered on July 27, 28, 29, 30 and 31, 2025. The medication was to be administered 1 tablet by mouth one time a day. Further review of the MAR revealed MA A documented an UN in the section meant for administered medication indicating unavailable medication for July 28 and 29, 2025. Review also revealed MA C documented UN indicating unavailable for July 27, 30, 31 2025. During an interview on 09/30/2025 at 9:45a.m, RP P stated she was the responsible party for Resident #1. RP P stated on 07/26/25, she had a 90-day supply of glimepiride for diabetes delivered to the facility. The staff lost the medication. The facility informed her that they would have the doctor renew the medication which they did not do as promised. On 07/31/25, the facility still had no medication for the resident. The RP explained she complained to the facility corporate office, and DON assured her the facility will provide the medication and pay for it. She was assured by DON and staff that they had the medication in stock and had been administering the medication to Resident #1. The RP P stated, the resident may have missed his medication for more than four days. The RP P explained the glimepiride was a significant medication used for control of his diabetes mellitus. She stated not taking this medicine will complicate [KS5] the control of his blood sugar resulting in serious harm to his health. In an interview with MA B on 09/30/25 at 1:30p.m, she stated she was the medication aide working on hall 200 where Resident #1 was residing. She said she did not give Resident #1 his glimepiride medication on July 28 and 29, 2025 as ordered. This was because the medication was not available. MA A explained that the family supplies the medication for the resident. She notified the charge nurse that the medication was not available to let the family know. MA A said she could not remember the charge nurse she informed. MA A added that it was a common practice to retrieve the medication from the E-kit (emergency kit) but did not remember if the charge nurse attempted to check the E-kit. She stated the medication was used to treat high blood sugar for diabetic residents. She noted Resident #1 could get diabetic complications [KS7] for not receiving the medication as ordered. During interview with MA C on 09/30/25 at 10:11a.m, she stated she has been working for the facility for 5 years and was responsible for giving medication to Resident #1. MA C confirmed she signed on Resident #1's MAR on July 27, 30 and 31, 2025 that the diabetic medication of glimepiride was not available. She stated one of days the medication was not available the resident's was in the room. The MA C informed wife the resident was out of the medication. MA C said the wife told her she had already filled the medication. MA C stated Resident #1's wife came back the next day and informed her the medication was already delivered and somebody from the facility signed for it. The continued and stated there was no longer a refill left because the order was already filled. MA C said she informed the nurse on</p>		